

CORK CHILDREN'S LIFESTYLE STUDY (CCLAS)

Parent Questionnaire

(To be filled out by the parent/guardian of the study child)

This questionnaire is part of the Cork Children's Lifestyle Study that you have consented for your child to take part in. It has been designed to examine the lifestyle and health of both you and your child. Questions included examine birth factors, physical activity levels and hobbies of your child. Questions specific to the parent/guardian include those on current health, the general family setting, physical activity and dietary factors.

Please attempt to answer every question. It should take about 20 minutes to fill in this questionnaire.

Your answers will be treated as strictly confidential and will be used only for the purposes of this study. This questionnaire can be returned in the envelope provided within the blue study folder your child has been provided with and we will collect it from your child's school.

If you would rather have the questionnaire administered by telephone, please contact the research team using the contact details below and we can arrange this.

Thank you for taking the time to provide this information. Your input will provide valuable information to the study.

Yours sincerely,

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Tel:
Email:



RELATIONSHIP TO STUDY CHILD:

Q1. Are you the child's: **SOURCE: DEVELOPED BY CCLaS RESEARCH TEAM**

☐ Mother

☐ Father

☐ Other (Please Specify)

A. STUDY CHILD'S BIRTH FACTORS

A.1. If known, how much did your child weigh at birth? **SOURCE: GUI**

Pounds

Ounces

OR

Kilos

Grams

☐

Don't Know

A.2. If known, was your child born late, on time or early? **SOURCE: GUI**

☐ Late Birth (42 weeks or more)

☐ Very Early (32 weeks or less)

☐ On Time (37-40 weeks)

☐ Don't Know

☐ Somewhat Early (33-36 weeks)

A.3. If known, what was the mode of delivery? **SOURCE: GUI**

☐ Normal Birth

☐ Emergency Caesarean

☐ Vacuum Assisted Birth

☐ Don't Know

☐ Forceps Assisted Birth

☐ Other

☐ Elective Caesarean

A.4. Was your child ever breastfed? **SOURCE: GUI**

☐ Yes

☐ No

☐ Don't Know

☐ Can't Remember

A.5. For how many months or weeks was your child breastfed? **SOURCE: GUI**

Months

OR

Weeks

OR

Days

☐ Don't Know

☐ Can't Remember

B. STUDY CHILDS CURRENT HEALTH

B.1. In general, how would you describe your child's health in the past year? **SOURCE: GUI**

☐ Very Healthy, no problems

☐ Sometimes quite ill

☐ Healthy, but with a few minor problems

☐ Almost always unwell

B.2. Does your child have any ongoing chronic physical or mental health problem, illness or disability such as Asthma, ADHD etc? **SOURCE: GUI**

☐ Yes

☐ Don't Know

☐ No

If No, please skip to question B.6.

B.3. What is the nature of this problem, illness or disability? Please describe as fully as possible. (Please record **diagnosis, not symptoms** of the problem) **SOURCE: GUI**

B.4. How old was your child when he/she was diagnosed with this problem, illness or disability? **SOURCE: GUI**

Months Old **OR** Years Old

B.5. Is your child hampered in his/her daily activities by this problem, illness or disability? **SOURCE: GUI**

☐ Yes, severely ☐ Yes, to some extent ☐ No

B.6. Do you think your child is: **SOURCE: GUI**

☐ Very underweight ☐ Slightly overweight
☐ Moderately underweight ☐ Moderately overweight
☐ Slightly underweight ☐ Very overweight
☐ About the right weight ☐ Don't know

B.7. Does your child go to bed at a regular time? **SOURCE: LSAC**

☐ Always ☐ Rarely
☐ Usually ☐ Never
☐ Sometimes

B.8. On **normal school days**, what time in the morning does your child usually wake up? **SOURCE: ALSPAC**

hours **minutes**
 am

B.9. On **normal school days**, what time in the evening does your child usually go to bed? **SOURCE: ALSPAC**

hours **minutes**
 pm

B.10. On **weekends**, what time in the morning does your child usually wake up? **SOURCE: ALSPAC**

hours **minutes**
 am

B.11. On **weekends**, what time in the evening does your child usually go to bed? **SOURCE: ALSPAC**

hours **minutes**
 pm

B.12. How often does your child brush his/her teeth (or have them brushed for him/her)? **SOURCE: NATIONAL SURVEY OF CHILDREN'S DENTAL HEALTH**

- ☐ My child's teeth are not usually brushed ☐ Twice a day
- ☐ Less than once a day (e.g. every second day, once a week) ☐ More than twice a day
- ☐ Once a day

C. STUDY CHILD'S EXERCISE AND PHYSICAL ACTIVITY

C.1. How many times in the **past 7 days** has your child done at **least 20 minutes of hard exercise**, hard enough to make him / her breathe heavily and make his / her heart beat **faster**? (Hard exercise includes, for example, playing football, jogging, or fast cycling). Include time in physical education class. **SOURCE: GUI**

- ☐ None ☐ 1 to 2 days ☐ 3 to 5 days ☐ 6 to 7 days

C.2. How many times in the **past 7 days** has your child done at **least 20 minutes of light exercise** that was **not** hard enough to make him / her breathe heavily and make his / her heart beat fast? (Light exercise includes, for example walking or slow cycling). Include time in physical education class. **SOURCE: GUI**

- ☐ None ☐ 1 to 2 days ☐ 3 to 5 days ☐ 6 to 7 days

C.3. How does your child usually (a) go to school and (b) come home from school? **SOURCE: GUI**

(Tick one box in Col A and B)

	A. Going	B. Coming Home
He/ she walks	<input type="checkbox"/>	<input type="checkbox"/>
By public transport	<input type="checkbox"/>	<input type="checkbox"/>
By public transport and walking	<input type="checkbox"/>	<input type="checkbox"/>
School bus/coach	<input type="checkbox"/>	<input type="checkbox"/>
By car	<input type="checkbox"/>	<input type="checkbox"/>
Rides a bicycle	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe) <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

C.4. How **long** does it take your child (a) to go to school (b) to come home from school? **SOURCE: GUI**

(Tick one box in Col A and B)

	A. Going	B. Coming Home
Less than 5mins	<input type="checkbox"/>	<input type="checkbox"/>
5 mins - less than 10 mins	<input type="checkbox"/>	<input type="checkbox"/>
10 mins - less than 20 mins	<input type="checkbox"/>	<input type="checkbox"/>
20 mins - less than 30 mins	<input type="checkbox"/>	<input type="checkbox"/>
30 mins or more	<input type="checkbox"/>	<input type="checkbox"/>

D. YOUR CHILD'S HOBBIES AND ACTIVITIES

D.1. On a **normal weekday** during term time, how many hours does your child spend watching **television, videos or DVDs?** Please remember to include time before school as well as time after school. **SOURCE: GUI**

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> 3 hours to less than 5 hours |
| <input type="checkbox"/> Less than an hour | <input type="checkbox"/> 5 hours to less than 7 hours |
| <input type="checkbox"/> 1 hour to less than 3 hours | <input type="checkbox"/> 7 hours or more |

D.2. On a **normal weekday** during term time, about how many hours does your child spend **reading** for pleasure [NOT during school hours]? Include time when the child reads to themselves or is read to by someone else. Do not include time spent listening to books on audio tapes, records, cds or a computer. **SOURCE: GUI**

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> 3 hours to less than 5 hours |
| <input type="checkbox"/> Less than an hour | <input type="checkbox"/> 5 hours to less than 7 hours |
| <input type="checkbox"/> 1 hour to less than 3 hours | <input type="checkbox"/> 7 hours or more |

D.3. On a **normal weekday** during term time, about how many hours does your child spend using the **computer and non-active game consoles (Playstation, X-box etc).** Please include time before school as well as time after school. DO NOT include time spent using computers in school. **SOURCE: GUI**

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> 3 hours to less than 5 hours |
| <input type="checkbox"/> Less than an hour | <input type="checkbox"/> 5 hours to less than 7 hours |
| <input type="checkbox"/> 1 hour to less than 3 hours | <input type="checkbox"/> 7 hours or more |

D.4. On a **normal weekday** during term time, about how many hours does your child spend playing **active games consoles such as Nintendo Wii etc?** Please include time before school as well as time after school. **SOURCE: GUI**

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> 3 hours to less than 5 hours |
| <input type="checkbox"/> Less than an hour | <input type="checkbox"/> 5 hours to less than 7 hours |
| <input type="checkbox"/> 1 hour to less than 3 hours | <input type="checkbox"/> 7 hours or more |

D.5. On days when your child is given homework, how much time does he or she spend doing **homework?** **SOURCE: GUI**

- | | |
|---|---|
| <input type="checkbox"/> 0 to 15 minutes | <input type="checkbox"/> 2 to less than 3 hours |
| <input type="checkbox"/> 16 to 30 minutes | <input type="checkbox"/> 3 to less than 4 hours |
| <input type="checkbox"/> 31 minutes to less than 1 hour | <input type="checkbox"/> 4 hours or more |
| <input type="checkbox"/> 1 to less than 1.5 hours | |
| <input type="checkbox"/> 1.5 to less than 2 hours | |

E. YOUR CHILD'S DIET AND DIETARY HABITS

E.1. What type of milk does your child **typically** consume whilst at home? (Please Tick One) **SOURCE: SLÁN**

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Skimmed |
| <input type="checkbox"/> Whole/ Full fat | <input type="checkbox"/> Super/ Fortified |
| <input type="checkbox"/> Low Fat | <input type="checkbox"/> Other <input type="text"/> |

E.2. Approximately, how much milk did your child drink in the **last 24 hours?** [This refers to the total amount of all milk full cream and skimmed that was drunk]. A small glass of milk contains approximately 100mls while a large glass contains approximately 250mls. **SOURCE: GUI**

- | | |
|--|--|
| <input type="checkbox"/> Up to ½ pint (approx. 250mls) | <input type="checkbox"/> 1 - 1 ½ pints (approx. 500 - 1000mls) |
| <input type="checkbox"/> ½ - 1 pint (approx. 250 - 500mls) | <input type="checkbox"/> More than 1 ½ pints (more than 1000mls) |

E.3. What type of **spread** does your child **usually** use on bread? (Please Tick One) **SOURCE: SLÁN**

- ☐ Butter or hard margarine (e.g. Kerrygold)
- ☐ A low fat or polyunsaturated spread (e.g. LowLow)
- ☐ A cholesterol lowering spread (e.g. Flora Proactive, Kilkeely Gold Low Cholesterol Spread)
- ☐ None
- ☐ Other:

E.4. Does your child usually have something to eat **before going to school?** **SOURCE: GUI**

- ☐ Yes ☐ No

E.5. Does your child usually have a meal in the **evening** during the week? **SOURCE: GUI**

- ☐ Yes ☐ No ☐ Sometimes

E.6. If yes, does your child usually **sit** at a table for the evening meal? **SOURCE: GUI**

- ☐ Yes ☐ No

E.7. Does your child consume fruit? **SOURCE: DEVELOPED BY CCLaS RESEARCH TEAM**

- ☐ Yes ☐ No

E.8. Does your child consume vegetables? **SOURCE: DEVELOPED BY CCLaS RESEARCH TEAM**

☐ Yes

☐ No

E.9. How many cans (330ml) or small bottles (up to 500ml) of **soft drinks** does your child usually have per week?

Bottles

OR

Cans

SOURCE: ALSPAC

E.10. How many cans (330ml) or small bottles (up to 500ml) of **energy or sports drinks** does your child usually have per week? **SOURCE: ALSPAC**

Bottles

OR

Cans

E.11. Has your child had any of the following supplements in the last 12 months? (Tick all that apply) **SOURCE: ALSPAC**

None ☐

Calcium ☐

Vitamin C ☐

Vitamin D ☐

☐ Iron

☐ Cod liver oil

☐ Multivitamins

☐ Other _____

E.12. How often has your child taken supplements in the **last 12 months?** **SOURCE: ALSPAC**

☐ Never

☐ Yes, takes them most days (Please give full name of supplement)

☐ Yes, takes them occasionally (Please give full name of supplement)

E.13. Is your child on any type of **special diet** e.g. vegetarian, vegan, coeliac etc.? **SOURCE: GU**

☐ Yes

☐ No

If yes, please specify

E.14. Please tick **one** box for each statement below: **SOURCE: CHILD FEEDING QUESTIONNAIRE**

	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree
I have to be sure that my child does not eat too many sweets (candy, ice-cream, cake or pastries)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have to be sure that my child does not eat too many high fat foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have to be sure that my child does not eat too much of his/her favourite foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I intentionally keep some foods out of my child's reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I offer sweets (candy, ice cream, cake, pastries) to my child as a reward for good behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I offer my child her favourite foods in exchange for good behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I did not guide or regulate my child's eating, s/he would eat too many junk foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I did not guide or regulate my child's eating, s/he would eat too much of his/her favourite foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F. CURRENT PARENT/GUARDIAN HEALTH

F.1. In general would you say **your** health is...? **SOURCE: GUI**

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

F.2. What is **your** height without shoes? **SOURCE: GUI**

Feet Inches **OR** Centimetres ☐ Don't Know

F.3. What is **your** weight without clothes and shoes? **SOURCE: GUI**

Stone Lbs **OR** Kilograms ☐ Don't Know

F.4. Where applicable, what is your **partner's** height without shoes? **SOURCE: GUI**

Feet Inches **OR** Centimetres ☐ Don't Know

F.5. Where applicable, what is your **partner's** weight without clothes and shoes? **SOURCE: GUI**

Stone Lbs **OR** Kilograms ☐ Don't Know

F.6. Do you think that you are? SOURCE: GUI

- | | |
|---|--|
| <input type="checkbox"/> Very underweight | <input type="checkbox"/> Slightly overweight |
| <input type="checkbox"/> Moderately underweight | <input type="checkbox"/> Moderately overweight |
| <input type="checkbox"/> Slightly underweight | <input type="checkbox"/> Very overweight |
| <input type="checkbox"/> About the right weight | <input type="checkbox"/> Don't know |

F.7. How often do you try to lose weight through dieting? SOURCE: GUI

- | | |
|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Very Often | <input type="checkbox"/> Rarely |
| <input type="checkbox"/> Often | <input type="checkbox"/> Never |
| <input type="checkbox"/> Sometimes | |

F.8. Have you ever been told by a doctor that you or your partner have, or have had any of the following conditions? SOURCE: MITCHELSTOWN COHORT STUDY

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	If <u>Yes</u> , Please Answer	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
Hypertension/ High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
Gestational Hypertension (during pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
Gestational Diabetes (during pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
Other (Please Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Me	<input type="checkbox"/> Partner
<div style="border: 1px solid black; height: 20px; width: 270px;"></div>					

Smoking

F.9. Which statement best describes the rules about smoking inside your home? **SOURCE: SLÁN**

- ☐ Smoking is not allowed anywhere inside the house
- ☐ Smoking is allowed in some places or at some times
- ☐ Smoking is allowed everywhere inside the house
- ☐ Don't know

F.10. Do you now smoke every day, some days, or not at all? **SOURCE: SLÁN**

- ☐ Every day
- ☐ Some days
- ☐ Not at all

F.11. Have you yourself smoked at least 100 cigarettes in your entire life? (5 packs = 100 cigarettes) **SOURCE: SLÁN**

- ☐ Yes
- ☐ No

Alcohol

F.12. How often do you have a drink containing alcohol? **SOURCE: SLÁN**

- ☐ Never
- ☐ 2-3 times a week
- ☐ Monthly or less
- ☐ 4 or more times a week
- ☐ 2 - 4 times a month

F.13. **How many** drinks containing alcohol do you have on a typical day when you are drinking? **SOURCE: SLÁN**

Please note that a standard drink is:

- a half pint or a glass of beer, lager or cider
- a single measure of spirits (e.g. whiskey, vodka, gin)
- a single glass of wine, sherry or port
- bottle of alcopops (long neck)

F.14. How often do you have 6 or more [standard] drinks on one occasion? **SOURCE: SLÁN**

- ☐ Everyday
- ☐ 1-3 times a month
- ☐ 5-6 times a week
- ☐ Less often
- ☐ 2-4 times a week
- ☐ Never
- ☐ Once a week

Exercise and Physical Activity

NOTE: IF 0 DAYS PER WEEK -ENTER 0 HOURS & 0 MINS - ALL 3 SECTIONS OF EACH Q [DAYS, HOURS & MINS MUST BE FILLED IN

F.15. Think about all the **vigorous activities** that you did in the last 7 days. Vigorous physical activities refer to activities that take hard physical effort and make you **breathe much harder** than normal. Think only about those physical activities that you did for at least 10 minutes at a time. During the **last 7 days**, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling? **SOURCE: I-PAQ**

Days per week

If No vigorous physical activities please skip to question F.18

F.16. How much time did you usually spend doing vigorous physical activities on one of those days? **SOURCE: I-PAQ**

Hours per day Minutes per day ☐ Don't Know/Not sure

F.17. Think about all the **moderate activities** that you did in the last 7 days. Moderate activities refer to activities that take moderate physical effort and make you **breathe somewhat harder** than normal. Think only about those physical activities that you did for at least 10 minutes at a time. During the **last 7 days**, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace or doubles tennis? Do not include walking. **SOURCE: I-PAQ**

Days per week

If No moderate physical activities please skip to question F.20

F.18. How much time did you usually spend doing moderate physical activities on one of those days? **SOURCE: I-PAQ**

Hours per day Minutes per day ☐ Don't Know/Not sure

F.19. Think about the time you spent **walking** in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise or leisure. During the **last 7 days**, on how many days did you walk for at least 10 minutes at a time? **SOURCE: I-PAQ**

Days per week

If No walking please skip to question F.22

F.20. How much time did you spend walking on one of those days? **SOURCE: I-PAQ**

Hours per day

Minutes per day

☐

Don't Know/ Not sure

F.21. Think about the time spent **sitting** in the last 7 days. Include time spent in work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading or sitting or lying down to watch television. During the **last 7 days**, how much time did you spend sitting on a **weekday**? **SOURCE: I-PAQ**

Hours per day

Minutes per day

☐

Don't Know/ Not sure

Well being **SOURCE: WEMWBS**

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling interested in other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've had energy to spare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been dealing with problems well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling good about myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling confident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been able to make up my own mind about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling loved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been interested in new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling cheerful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. PARENT/GUARDIAN DIET

G.1. How often do you eat fried food? SOURCE: SLÁN

- | | |
|---|--|
| <input type="checkbox"/> Daily | <input type="checkbox"/> 4-6 times a week |
| <input type="checkbox"/> 1-3 times a week | <input type="checkbox"/> Less than once a week |

G.2. How often do you add salt to food while at the table? SOURCE: SLÁN

- | | |
|------------------------------------|---------------------------------|
| <input type="checkbox"/> Always | <input type="checkbox"/> Rarely |
| <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| <input type="checkbox"/> Sometimes | |

G.3. How often do you add salt to food while cooking? SOURCE: SLÁN

- | | |
|------------------------------------|---------------------------------|
| <input type="checkbox"/> Always | <input type="checkbox"/> Rarely |
| <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| <input type="checkbox"/> Sometimes | |

G.4. On average, how many portions of fruit do you eat per day? SOURCE: DEVELOPED BY CCLaS RESEARCH TEAM

_____ portions per day

G.5. On average, how many portions of vegetables do you eat per day? SOURCE: DEVELOPED BY CCLaS RESEARCH TEAM

_____ portions per day

G.6. Did you eat snacks between your meals yesterday? SOURCE: SLÁN

- ☐ Yes
- ☐ No

G.6.i. If yes, how many snacks did you eat yesterday:

SOURCE: SLÁN

G.6.ii. If yes, what type of snacks did you eat yesterday? (Please tick all that apply) SOURCE: SLÁN

- | | | |
|---|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Biscuits/ Cake | <input type="checkbox"/> Scone | <input type="checkbox"/> Dried fruit |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Yoghurt | <input type="checkbox"/> Vegetables |
| <input type="checkbox"/> Crisps/Popcorn/ Pretzels | <input type="checkbox"/> Fruit | <input type="checkbox"/> Nuts |
| <input type="checkbox"/> Other | <input type="text"/> | |

H. GENERAL FAMILY EATING QUESTIONS **SOURCE: SLÁN**

H.1. What type of fat/oil would you usually use for cooking? **(Please Tick One)**

- ☐ Vegetable Oil ☐ Sunflower Oil ☐ Olive Oil/ Rapeseed oil
☐ Lard or dripping ☐ None ☐ Other _____

H.2. How often does your family order take away in a typical week? **SOURCE: DEVELOPED BY CCLaS RESEARCH**

- ☐ Daily ☐ 1-3 times a week ☐ 4- 6 times a week ☐ Less than once a week

H.3. How often does your family eat out in a typical week? **SOURCE: DEVELOPED BY CCLaS RESEARCH**

- ☐ Daily ☐ 1-3 times a week ☐ 4- 6 times a week ☐ Less than once a week

H.4. What type of restaurant does your family typically eat out in? **SOURCE: DEVELOPED BY CCLaS RESEARCH**

- ☐ Standard restaurant ☐ Café ☐ Fast food restaurant ☐ Other:

H.5. Can you afford to buy enough food for your household? **SOURCE: SLÁN**

- ☐ Always ☐ Sometimes ☐ Usually
☐ Rarely ☐ Never

H.6. During the past 7 days, how many times did all, or most, of your family living in your house eat a meal together? **SOURCE: EAT-1**

- ☐ Never ☐ 1-2 times ☐ 3-4 times
☐ 5-6 times ☐ 7 times ☐ More than 7 times

I. FAMILY BACKGROUND

I.1 How many people in total (including yourself and all children of all ages) regularly live as members of your household? **SOURCE: GUI**

Persons

I.2. For each member of the household, including yourself, could you tell me their relationship to the study child? **SOURCE: GUI**

Person	Gender	Date Of Birth	Age at last birthday	Relationship to STUDY CHILD
1	<input type="checkbox"/> Male <input type="checkbox"/> Female			
2	<input type="checkbox"/> Male <input type="checkbox"/> Female			
3	<input type="checkbox"/> Male <input type="checkbox"/> Female			
4	<input type="checkbox"/> Male <input type="checkbox"/> Female			
5	<input type="checkbox"/> Male <input type="checkbox"/> Female			
6	<input type="checkbox"/> Male <input type="checkbox"/> Female			
7	<input type="checkbox"/> Male <input type="checkbox"/> Female			

I.3 What is your ethnic background? SOURCE: IRISH CENSUS

- | | |
|---|--|
| <input type="checkbox"/> Irish | <input type="checkbox"/> Any other Black background |
| <input type="checkbox"/> Irish Traveller | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Any other White background | <input type="checkbox"/> Any other Asian background |
| <input type="checkbox"/> African | <input type="checkbox"/> Other, incl. mixed background |

Please Specify:

I.4. What is your current marital status? (Please select one answer) SOURCE: MITCHELSTOWN COHORT STUDY

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Cohabiting | <input type="checkbox"/> Widowed |

I.5. Does your family have the use of a car? (Including vans, minibuses etc) SOURCE: SLÁN

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

I.6. What is the highest level of education you have completed to date? (Please select one answer) SOURCE: GUI

- ☐ Primary or less
- ☐ Intermediate/ Junior/ Group Certificate or equivalent
- ☐ Leaving Certificate or equivalent
- ☐ Diploma or Certificate
- ☐ Primary degree
- ☐ Postgraduate/ Higher degree
- ☐ Refusal

I.7. Which of these descriptions BEST describes your usual situation in regard to work? (Please select one answer)

- | | |
|--|--|
| <input type="checkbox"/> Employee (incl. Apprenticeship or Community Employment) | <input type="checkbox"/> Unemployed, actively looking for a job |
| <input type="checkbox"/> Self employed outside farming | <input type="checkbox"/> Long term sickness or disability |
| <input type="checkbox"/> Farmer | <input type="checkbox"/> Home duties/ looking after home or family |
| <input type="checkbox"/> Student Full-time | <input type="checkbox"/> Retired |
| <input type="checkbox"/> On state training scheme (FAS, Failte Ireland) | <input type="checkbox"/> Other (specify) SOURCE: GUI |

I.8. How many hours do you normally work per week, including any regular overtime work? SOURCE: GUI

If you work at more than one job, please include the hours in all jobs. hours

I.9. What is your occupation in this job? (What do you mainly do in your job?) Please describe as fully as possible.

SOURCE: GUI

I.10. Do you supervise or manage any personnel in your job? **SOURCE: GUI**

☐ Yes

☐ No

I.11. If yes, how many people do you supervise or manage? ____ **SOURCE: GUI**

I.12. If self employed, how many employees (if any) do you have?

SOURCE: GUI

☐ N/A

I.13. Does anyone other than yourself and/or your spouse/partner provide care to the Study Child on a regular basis for 8 hours or more each week? **SOURCE: GUI**

☐ Yes

☐ No

I.14. If yes, is this form of childcare provided in: **SOURCE: DEVELOPED BY CCLaS RESEARCH**

☐ The child's home

☐ A Relatives home

☐ Home of carer-non relative

☐ Centre (crèche, after school activity)

I.15. Approximately how many days per week does the Study Child spend in this form of childcare? **SOURCE: GUI**

days per week

I.16. Is this form of childcare paid or non-paid?

☐ Paid

☐ Non Paid

The remaining questions are about your partner- where applicable, please fill in this section

I.17. Where applicable, what is the highest level of education that your partner has completed to date? **(Please select one answer)** **SOURCE: GUI**

☐ Primary or less

☐ Intermediate/ Junior/ Group Certificate or equivalent

☐ Leaving Certificate or equivalent

☐ Diploma or Certificate

☐ Primary degree

☐ Postgraduate/ Higher degree

☐ Refusal

I.18. Where applicable, which of these descriptions **BEST** describes **your partners** usual situation in regard to work? (Please select one answer) **SOURCE: GUI**

- | | |
|--|--|
| <input type="checkbox"/> Employee (incl. Apprenticeship or Community Employment) | <input type="checkbox"/> Unemployed, actively looking for a job |
| <input type="checkbox"/> Self employed outside farming | <input type="checkbox"/> Long term sickness or disability |
| <input type="checkbox"/> Farmer | <input type="checkbox"/> Home duties/ looking after home or family |
| <input type="checkbox"/> Student Full-time | <input type="checkbox"/> Retired |
| <input type="checkbox"/> On state training scheme (FAS, Failte Ireland) | <input type="checkbox"/> Other (specify) |

I.19. How many hours does your partner normally work per week, including any regular overtime work? If your partner works at more than one job, please include the hours in all jobs Hours **SOURCE: GUI**

I.20. What is your partner's occupation in this job? (What do you mainly do in your job?) Please describe as fully as possible. **SOURCE: GUI**

I.21. Does your partner supervise or manage any personnel in his/her job? **SOURCE: GUI**

☐ Yes

☐ No

I.21. If yes, how many people does he/she supervise or manage? person/people **SOURCE: GUI**

I.22. If your partner is self employed, how many employees (if any) does he/she have? employees

☐ N/A **SOURCE: GUI**

Thank you once again for your participation